FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2019)

I. IDPH License ID Number: 0052431

Facility Name: Norridge Gardens

Address: 7001 West Cullom (Number) Norridge (City) 60706 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2014

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/19 to 12/31/19 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	292	Skilled (SNF)	292	106,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	292	TOTALS	292	106,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	829		14,606	15,435	8
9	SNF/PED					9
10	ICF	65,596	7,640		73,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,425	7,640	14,606	88,671	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.20%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 292 and days of care provided 12,927

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/19 Fiscal Year: 12/31/19

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	841,686	41,275	40,068	923,029		923,029		923,029			1
2	Food Purchase		653,429		653,429		653,429		653,429			2
3	Housekeeping	387,619	50,879		438,498		438,498		438,498			3
4	Laundry	129,207	54,040		183,247		183,247		183,247			4
5	Heat and Other Utilities			236,314	236,314		236,314	2,981	239,295			5
6	Maintenance	141,249		153,213	294,462		294,462	26,871	321,333			6
7	Other (specify):* Waste Removal			28,467	28,467		28,467		28,467			7
8	TOTAL General Services	1,499,761	799,623	458,062	2,757,446		2,757,446	29,852	2,787,298			8
	B. Health Care and Programs											
9	Medical Director			101,600	101,600		101,600		101,600			9
10	Nursing and Medical Records	6,792,081	540,004	52,315	7,384,400		7,384,400	137,940	7,522,340			10
10a	Therapy	396,922	278	90,643	487,843		487,843	(78,643)	409,200			10a
11	Activities	278,651		28,090	306,741		306,741		306,741			11
12	Social Services	181,328		2,808	184,136		184,136		184,136			12
13	CNA Training											13
14	Program Transportation			16,866	16,866		16,866		16,866			14
15	Other (specify):* Mgmt Co Benefits Alloc							28,825	28,825			15
16	TOTAL Health Care and Programs	7,648,982	540,282	292,322	8,481,586		8,481,586	88,122	8,569,708			16
	C. General Administration											
17	Administrative	277,050		1,123,279	1,400,329		1,400,329	(940,708)	459,621			17
18	Directors Fees											18
19	Professional Services			680,300	680,300		680,300	86,373	766,673			19
20	Dues, Fees, Subscriptions & Promotions			99,969	99,969		99,969	47,535	147,504			20
21	Clerical & General Office Expenses	368,272	79,415	329,473	777,160		777,160	370,119	1,147,279			21
22	Employee Benefits & Payroll Taxes			1,588,169	1,588,169		1,588,169		1,588,169			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,820	10,820		10,820	1,056	11,876			24
25	Other Admin. Staff Transportation			32,242	32,242		32,242	1,691	33,933			25
26	Insurance-Prop.Liab.Malpractice			98,445	98,445		98,445	3,702	102,147			26
27	Other (specify):* Mgmt Co Benefits Alloc							114,129	114,129			27
28	TOTAL General Administration	645,322	79,415	3,962,697	4,687,434		4,687,434	(316,103)	4,371,331			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,794,065	1,419,320	4,713,081	15,926,466		15,926,466	(198,129)	15,728,337			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norridge Gardens #0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			140,573	140,573		140,573	13,678	154,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			295,150	295,150		295,150	3,385	298,535			32
33	Real Estate Taxes			398,471	398,471		398,471		398,471			33
34	Rent-Facility & Grounds			3,950,940	3,950,940		3,950,940	43,118	3,994,058			34
35	Rent-Equipment & Vehicles			95,464	95,464		95,464	5,367	100,831			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,880,598	4,880,598		4,880,598	65,548	4,946,146			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		639,718	2,265,420	2,905,138		2,905,138	(288,361)	2,616,777			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			599,763	599,763		599,763		599,763			42
43	Other (specify):* Non-Allowable Exp	220,904	19,380	487,525	727,809		727,809	(727,809)				43
44	**TOTAL Special Cost Centers**	220,904	659,098	3,352,708	4,232,710		4,232,710	(1,016,170)	3,216,540			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,014,969	2,078,418	12,946,387	25,039,774		25,039,774	(1,148,751)	23,891,023			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,540)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,165)	30		9
10	Interest and Other Investment Income	(10,209)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,581)	43		18
19	Entertainment				19
20	Contributions	1,627	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,777)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(372,694)	43		24
25	Fund Raising, Advertising and Promotional	(114,799)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(192,160)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (773,298)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(375,453)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (375,453)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,148,751)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Norridge Gardens

ID# 0052431

Report Period Beginning: 1/1/19

Ending: 12/31/19

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (220,904)	43	1
2	Miscellaneous Income offset	(100)	21	2
3	Expense Repairs under $2,500	4,752	10	3
4	Expense Repairs under $2,500	25,801	6	4
5	Expense Repairs under $2,500	2,462	21	5
6	Disallow Theft Loss	(918)	43	6
7	Disallow Marketing Travel Exp	(3,253)	25	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(192,160)		49

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$				$	1
2	V		See Page 6A						2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 2,981	$ 2,981	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	1,070	1,070	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	133,188	133,188	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	28,825	28,825	18
19	V	17	Administrative	1,123,279	Premier Healthcare Management, LLC	100.00%	182,571	(940,708)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	68,590	68,590	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	23,523	23,523	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	366,467	366,467	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	1,056	1,056	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	3,378	3,378	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	114,129	114,129	25
26	V	30	Depreciation		Premier Healthcare Management, LLC	100.00%	70,507	70,507	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	43,118	43,118	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	5,367	5,367	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,123,279			$ 1,044,770	$ * (78,509)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Therapy	$ 78,643	REX Therapeutics	100.00%	$	$ (78,643)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	21,560	21,560	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	24,012	24,012	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	1,290	1,290	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	1,566	1,566	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	3,702	3,702	20
21	V	30	Depreciation		REX Therapeutics	100.00%	4,336	4,336	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	13,594	13,594	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	7,937	7,937	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	72,179	72,179	24
25	V								25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	1,555,305	1,555,305	27
28	V	39	Contract Therapy	2,096,381	REX Therapeutics	100.00%		(2,096,381)	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	172,599	172,599	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,175,024			$ 1,878,080	$ * (296,944)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Barak Baver	0.25	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	David Cheplowitz	0.25	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Erez Baver	0.05	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Netzach Investments	0.45	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5			Gardenview Manor	Danville	REX Therapeutics	Skokie	Therapy	5
6			Champaign Urbana Nursing and Rehab	Savoy				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sara Baver	Relative	Clerical	0.00	See Att Sch 7A	15.93	39.81	Alloc Salary	$ 17,601	21-7	1
2	Yocheved Baver	Relative	Consulting	0.00	See Att Sch 7A			Consulting	10,800	19-3	2
3	Erez Baver	Relative	Consulting	5.00	See Att Sch 7A			Consulting	35,000	19-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 63,401		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	222,666	6	$ 7,486	$	88,671	$ 2,981	1
2	6	Maintenance	Census Days	222,666	6	2,688		88,671	1,070	2
3	10	Nursing and Medical Records	Census Days	222,666	6	334,454	334,454	88,671	133,188	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	222,666	6	72,385		88,671	28,825	4
5	17	Administrative	Census Days	222,666	6	458,462	458,462	88,671	182,571	5
6	19	Professional Services	Census Days	222,666	6	84,350		88,671	33,590	6
7	20	Dues, Fees, Subs & Promo	Census Days	222,666	6	59,069		88,671	23,523	7
8	21	Clerical & Gen Office Expenses	Census Days	222,666	6	920,255	865,736	88,671	366,467	8
9	24	Travel and Seminar	Census Days	222,666	6	2,652		88,671	1,056	9
10	25	Other Admin. Staff Trans	Census Days	222,666	6	8,485		88,671	3,378	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	222,666	6	286,594		88,671	114,129	11
12	30	Depreciation	Census Days	222,666	6	177,052		88,671	70,507	12
13	34	Rent-Facility & Grounds	Census Days	222,666	6	108,276		88,671	43,118	13
14	35	Equipment Rental	Census Days	222,666	6	13,478		88,671	5,367	14
15										15
16	19	Professional Services	Direct Allocation	35,000	1	35,000		35,000	35,000	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,570,686	$ 1,658,652		$ 1,044,770	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Therapy Revenue	8,776,257	12	$ 86,929	$	2,176,719	$ 21,560	1
2	20	Fees and Subscriptions	Therapy Revenue	8,776,257	12	96,810		2,176,719	24,012	2
3	21	Clerical & General Office Exp	Therapy Revenue	8,776,257	12	5,201		2,176,719	1,290	3
4	25	Other Admin Staff Transp	Therapy Revenue	8,776,257	12	6,315		2,176,719	1,566	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	8,776,257	12	14,928		2,176,719	3,702	5
6	30	Depreciation	Therapy Revenue	8,776,257	12	17,481		2,176,719	4,336	6
7	32	Interest Expense	Therapy Revenue	8,776,257	12	54,809		2,176,719	13,594	7
8	39	Therapy Consultant	Therapy Revenue	8,776,257	12	32,000		2,176,719	7,937	8
9	39	Therapy Management Wages	Therapy Revenue	8,776,257	12	291,015	291,015	2,176,719	72,179	9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	5,980,902	10	5,689,887	5,689,887	1,555,305	1,555,305	12
13	39	Contract Therapy	Direct Allocation	408,806	5	408,806				13
14	39	Allocated Employee Benefits	Total Wages	5,980,902	10	634,319		1,627,484	172,599	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,338,500	$ 5,980,902		$ 1,878,080	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1												1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit		12/31/14		3,900,000			234,878	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,900,000			$ 234,878	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			40,083	10
11								Allocated from REX Therapeutics			13,594	11
12								Offset Interest Income			(10,209)	12
13								Other Interest Expense			20,189	13
14	TOTAL Non-Facility Related						$	$			$ 63,657	14
15	TOTALS (line 9+line14)						$	$ 3,900,000			$ 298,535	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2018 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2019 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 703,829	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 152,679	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 458,037 For 2016-2018 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (458,037)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 398,471	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2014	942,879	8
	2015	952,726	9
	2016	978,728	10
	2017	1,035,678	11
	2018	1,067,795	12

Accrual based on prior year tax bill.
The beginning accrual was adjusted for a 2018 post closing entry

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2018	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Gardens COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052431

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2018 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2018.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-18-318-005-0000	Long Term Care Propety	$ 285,154.65	$ 285,154.65
2.	13-18-318-006-0000	Long Term Care Propety	$ 253,023.95	$ 253,023.95
3.	13-18-318-007-0000	Long Term Care Propety	$ 255,172.09	$ 255,172.09
4.	13-18-318-008-0000	Long Term Care Propety	$ 274,444.35	$ 274,444.35
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,067,795.04	$ 1,067,795.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replace Elevator Door Operator			2013	11,472		20	574	574	3,300	9
10	Replace Pumping Unit			2013	13,952		20	698	698	4,013	10
11	Boiler Repair & Rtu			2013	5,992		20	300	300	3,996	11
12	Build Wood Planters			2013	12,750		20	638	638	3,720	12
13	Sprinkler System Heads & Valves In Parking Lot Foyer & South Dock			2013	3,388		20	169	169	987	13
14	Install Awning & Sign			2013	8,944		20	447	447	2,497	14
15	Fire Sprinkler Repair			2014	2,929		20	146	146	804	15
16	Re-Doing Wiring And Computer Systems			2014	22,057		20	1,103	1,103	5,974	16
17	Repair Staircases On All 4 Floors			2014	6,600		20	330	330	1,705	17
18	Install Shunt Trip Breaker & Panelboard For Freight Elevator			2014	6,800		20	340	340	1,757	18
19	Hook Up Emergency Power & Fire Service Wiring			2014	5,010		20	251	251	1,275	19
20	Fire Doors			2014	3,000		20	150	150	750	20
21	Convert 2 Rms On 2Nd Floor To 2 Single Bedrms & Bathrm			2014	70,300		20	3,515	3,515	17,575	21
22	Fire Doors			2014	3,360		20	168	168	840	22
23	Water Heater Surface Ignitor			2014	3,957		20	198	198	2,507	23
24	Hot Water Pump Motor			2014	2,500		20	125	125	635	24
25	Install New Elevator Care Doors			2014	2,669		20	133	133	1,511	25
26	Install New Elevator Care Doors			2014	2,669		20	133	133	1,289	26
27	All Areas Carpet & Millwork Cove Base, Bathroom Tile			2014	31,551		20	1,578	1,578	7,889	27
28	Install New Elevator Care Doors			2014	2,669		20	133	133	655	28
29	Fire Alarm System			2014	4,270		20	214	214	980	29
30	Sprinkler System Repair			2014	2,523		20	126	126	588	30
31	Fire Alarm Repair			2014	3,264		20	163	163	843	31
32	Replace Packing & Repair Leaking Valves			2014	2,974		20	149	149	719	32
33	Hot Water Storage Tank Replacement With Wiring/Piping			2015	7,500		20	375	375	1,875	33
34	Idph Construction Application/Architects/Hvac/Electrical/Sprinkler			2015	8,496		20	425	425	2,125	34
35	Provide/Install New A/C Unit/Electrical Wiring For Lunch Room			2015	5,500		20	275	275	1,375	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Kitchen Cabinets/Counter Tops For 2Nd/3Rd Floor Dining Rooms	2015	2,662		20	133	$ 133	$ 665	37
38	Install Cabinets/Countertops/Plumbing For 2Nd/3Rd Floor Dining	2015	$ 3,550	$	20	$ 178	178	890	38
39	Structural Engineering/Calculations/Analysis For Floor Addition	2015	7,500		20	375	375	1,875	39
40	Provide/Install New Circuits Quad Outlets In 2Nd/3Rd Floor Spec	2015	2,680		20	134	134	670	40
41	Design Fees For First Floor Remodeling	2015	10,000		20	500	500	2,500	41
42	Replace Relief Device/Leak & Commission Test/Re-Insulate Tank	2015	7,500		20	375	375	1,875	42
43	Amstadter Construction Documents Detailed Architectural Design	2015	10,000		20	500	500	2,500	43
44	First Floor Remodel/Mechanical/Electrical/Plumbing/& Fire Prote	2015	10,000		20	500	500	2,500	44
45	Design Sketches First Floor Plans/Interior Elevations/Ceiling Plan	2015	10,000		20	500	500	2,500	45
46	Remove/Install New Retro Drains/Saddle For Roof/Iso Roofing Co	2015	3,200		20	160	160	800	46
47	Test/Replace Drive In Control System Contractor For Elevator	2015	2,932		20	147	147	735	47
48	Drilling 0-25'/Patching Of Asphalt/Soil Classification/ Project Rev	2015	4,360		20	218	218	1,090	48
49	Fertilization/Planting Flowers/Shrub & Tree Trimming In Back P	2015	2,730		20	137	137	685	49
50	Modify Pit Ladder/Hoistway Doors/Hatch Latch Door Restrictor I	2015	7,358		20	368	368	1,840	50
51	Replace/Repair leaking heat pipes & boiler water lines-2nd & 3rd	2016	4,238		20	212	212	742	51
52	Repaired Heat Exchanger	2016	3,528		20	176	176	616	52
53	Repair and Paint Walls in Office, Conference Rm & Kitchen	2016	5,425		20	271	271	949	53
54	Replace Tiles in Therapy Room	2016	3,900		20	195	195	683	54
55	Install Wanderguard Signalling Device	2016	3,454		20	173	173	605	55
56	New Refrigeration System with Indoor Remote Condensing	2016	11,399		20	570	570	1,995	56
57	2 9500 BTU Replacement units and 2 PTAC Units	2016	5,805		20	290	290	1,015	57
58	Carpet/Flooring - Lobby, Business Office, Conference Rm & Ente	2016	4,472		20	224	224	784	58
59	Replace Damaged Floor Tiles in Kitchen	2016	2,650		20	133	133	133	59
60	Install New Torsion-Spring Counter Balance Assembly	2016	2,650		20	133	133	133	60
61	Six new PTAC Units	2016	8,745		20	437	437	437	61
62	Install New 20 Ampere Circuitin Admissions Office	2017	5,000		20	250	250	250	62
63	Install 2 New 20 Ampere Circuits in Kitchen and 1 Power Pole	2017	3,500		20	175	175	175	63
64	Air Conditioner Repairs	2017	3,047		20	152	152	152	64
65	Replace Copper Piping and Strainer for Boiler	2017	3,032		20	152	152	152	65
66	Replace Bearing Assembly, Motor and Impeller for Boiler	2017	3,466		20	173	173	173	66
67	Six new PTAC Units	2017	8,553		20	428	428	428	67
68	Sprinkler System Repairs and Modifications - Maint. Office	2017	5,725		20	286	286	286	68
69									69
70	TOTAL (lines 4 thru 69)		$ 430,157	$		$ 21,511	$ 21,511	$ 103,017	70

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 430,157	$		$ 21,511	$ 21,511	$ 103,017	1
2	Replace Sink and Cabinets in Utility Rm/Flooring in Ent Rm	2017	3,682		20	184	184	460	2
3	Luna Lights System	2017	4,000		20	200	200	500	3
4	Furnace Repairs	2017	4,680		20	234	234	585	4
5	Architectural Design Plan Revisions	2017	9,780		20	489	489	734	5
6	8 PTAC Units	2018	11,263		20	563	563	845	6
7	Rewire items from Emergency to Critical Electrical Panel	2018	2,525		20	126	126	189	7
8	4 PTAC Units	2018	5,631		20	282	282	423	8
9	5 PTAC Units	2018	7,039		20	352	352	528	9
10	Replace 2 Flue Caps	2018	4,569		20	228	228	342	10
11	Elevator Repair	2018	4,303		20	215	215	323	11
12	Repair to Boiler	2019	2,731		20	68	68	68	12
13	Re-Piping 7 Front Offices	2019	16,594		20	415	415	415	13
14	Repair Pipes due to Freezing	2019	41,484		20	1,037	1,037	1,037	14
15	Install Solid State Soft Starter	2019	3,460		20	87	87	87	15
16	Install New Pump Motor on Elevator	2019	5,592		20	140	140	140	16
17	Replace Heat Coils-Kitchen, Laundry, Front Lobby	2019	18,887		20	472	472	472	17
18	Replace Compressor	2019	4,192		20	105	105	105	18
19	Generator Repair	2019	3,059		20	76	76	76	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27	Allocated from Premier Healthcare Management LLC.	2013	9,912		20	495	495	3,068	27
28									28
29	Allocated from REX Therapeutics					4,336	4,336		29
30									30
31	Financial Statement Depreciation			140,573			(140,573)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 593,540	$ 140,573		$ 31,615	$ (108,958)	$ 113,414	34

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 517,944	$	$ 51,794	$ 51,794	10 Yrs	$ 253,210	71
72	Current Year Purchases	16,596		830	830	10 Yrs	830	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co			70,012	70,012			74
75	TOTALS	$ 534,540	$	$ 122,636	$ 122,636		$ 254,040	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,128,080	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 140,573	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 154,251	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,678	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 367,454	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	292	7/1/13	$ 3,950,940			3
4	Additions							4
5	Allocated from Management Co.				43,118			5
6								6
7	TOTAL		292		$ 3,994,058 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2020	$
13.	/2021	$
14.	/2022	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 95,464 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	Allocated from Management Co			5,367	19
20					20
21	TOTAL		$	$ 5,367	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/19**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	81,969
Storage Site	8,481
Other Equipment Rental	5,014
Total - Line 16	**95,464**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens STATE OF ILLINOIS # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(7)	14240 hrs	$ 525,679		$	$	14,240	$ 525,679	1
2	Licensed Speech and Language Development Therapist	39(7)	5348 hrs	197,427				5,348	197,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2),39 (7)	22544 hrs	832,199			278	22,544	832,477	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				630,464		630,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy Manager-Allo	39(7)	516 hrs	72,179				516	72,179	12
13	Other (specify): See Attached Sch 16A					126,778	9,254		136,032	13
14	TOTAL			$ 1,627,484		$ 126,778	$ 639,996	42,648	$ 2,394,258	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/19**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	127,782
Outside MD Service-MCA	39(3)	(504)
Dental	39(3)	(500)
Medical Supplies - MCA	39(2)	9,254
Total - Line 13		**136,032**

STATE OF ILLINOIS

Facility Name & ID Number Norridge Gardens **#** 0052431 **Report Period Beginning:** 1/1/19 **Ending:** 12/31/19

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/19 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,515	$ 14,515	1
2	Cash-Patient Deposits	3,609	3,609	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,955,669)	6,126,109	6,126,109	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,815	47,815	6
7	Other Prepaid Expenses	273,966	273,966	7
8	Accounts Receivable (owners or related parties)	6,737,417	6,737,417	8
9	Other(specify): Due from Others	685,444	685,444	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,888,875	$ 13,888,875	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	828,463	593,540	15
16	Equipment, at Historical Cost	649,256	534,540	16
17	Accumulated Depreciation (book methods)	(793,952)	(367,454)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	37,034,344	37,034,344	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,718,111	$ 37,794,970	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 51,606,986	$ 51,683,845	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,678,858	$ 3,678,858	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(13)	(13)	28
29	Short-Term Notes Payable	3,900,000	3,900,000	29
30	Accrued Salaries Payable	722,085	722,085	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,495,844	1,495,844	31
32	Accrued Real Estate Taxes(Sch.IX-B)	703,829	703,829	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	2,257,452	2,257,452	36
37	Accrued Rent	936,202	936,202	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,694,257	$ 13,694,257	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capitalized Lease Liablility	37,084,984	37,084,984	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 37,084,984	$ 37,084,984	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 50,779,241	$ 50,779,241	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 827,745	$ 904,604	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 51,606,986	$ 51,683,845	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/19**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
CapEx Reserve	6,600	6,600
Building-Cap Lease	36,425,600	36,425,600
Unamortized Loan Costs	302,144	302,144
Escrow Deposits	300,000	300,000
Total - Line 23	**37,034,344**	**37,034,344**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	129,690	129,690
Accrued Expenses	108,520	108,520
Accrued Bed Tax	40,296	40,296
Payroll Withholdings	312,498	312,498
Security Deposits	352,663	352,663
Due to HFS	873,000	873,000
Due to Others	425,000	425,000
Due to Prior Owner	15,785	15,785

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 792,370	1
2	Restatements (describe):		2
3	**Post closing adjustments -Real Estate Taxes**	206,029	3
4	**Post closing adjustments - Forgiveness of Debt**	(465,795)	4
5	**Post closing adjustments -Misc Expense Corrections**	213	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 532,817	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	294,928	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 294,928	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 827,745	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,729,982	1
2	Discounts and Allowances for all Levels	3,280,272	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 24,010,254	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	832,987	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 832,987	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	38,850	16
17	Sale of Drugs	148	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(122)	20
21	Other Medical Services	3,012	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,888	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,209	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,209	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	100	28
28a	Prior Year Accrual Reversals	439,264	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 439,364	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 25,334,702	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,757,446	31
32	Health Care	8,481,586	32
33	General Administration	4,687,434	33
	B. Capital Expense		
34	Ownership	4,880,598	34
	C. Ancillary Expense		
35	Special Cost Centers	3,632,947	35
36	Provider Participation Fee	599,763	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 25,039,774	40
41	**Income before Income Taxes (line 30 minus line 40)****	294,928	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 294,928	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,035,250	44
45	Private Pay - Net Inpatient Revenue	2,119,488	45
46	Medicare - Net Inpatient Revenue	8,127,156	46
47	Other-(specify) Insurance	1,298,916	47
48	Other-(specify) Hospice	429,444	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 24,010,254	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,164	2,508	$ 165,743	$ 66.09	1
2	Assistant Director of Nursing	4,840	5,574	247,893	44.47	2
3	Registered Nurses	62,771	67,376	2,480,752	36.82	3
4	Licensed Practical Nurses	30,811	32,364	941,834	29.10	4
5	CNAs & Orderlies	151,958	165,739	2,724,593	16.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,511	18,661	396,922	21.27	8
9	Activity Director					9
10	Activity Assistants	16,853	18,488	278,651	15.07	10
11	Social Service Workers	8,631	9,484	181,328	19.12	11
12	Dietician					12
13	Food Service Supervisor	2,796	3,102	88,154	28.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	48,447	52,031	753,532	14.48	15
16	Dishwashers					16
17	Maintenance Workers	6,042	6,545	141,249	21.58	17
18	Housekeepers	27,260	29,477	387,619	13.15	18
19	Laundry	9,087	9,826	129,207	13.15	19
20	Administrator	3,584	2,275	204,228	89.77	20
21	Assistant Administrator	1,864	2,040	72,822	35.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,250	20,771	368,272	17.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,306	2,563	85,652	33.42	31
32	Other Health Care(specify)					32
33	Other(specify) See Att Sch 20A	6,968	7,432	366,518	49.32	33
34	TOTAL (lines 1 - 33)	422,143	456,256	$ 10,014,969 *	$ 21.95	34

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 39,994	L1, C3	35
36	Medical Director	Monthly	76,500	L9, C3	36
37	Medical Records Consultant			L10, C3	37
38	Nurse Consultant	Monthly	4,090	L10, C3	38
39	Pharmacist Consultant	Monthly	35,170	L10, C3	39
40	Physical Therapy Consultant	Monthly	7,937	L39,C7	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	42,261	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	220	L11, C3	44
45	Social Service Consultant	47	2,808	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	12,000	L10A, C3	46
47	Medical Consulting	22	25,100	L9,C3	47
48					48
49	TOTAL (lines 35 - 48)	73	$ 246,080		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	626	L10,C3	51
52	Certified Nurse Assistants/Aides	393	12,429	L10,C3	52
53	TOTAL (lines 50 - 52)	401	$ 13,055		53

Norridge Gardens

Period Beginning **1/1/19**
Period End **12/31/19**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		3,928	4,256	145,614	34.21
Marketing		3,040	3,176	220,904	69.55
	TOTAL	6,968	7,432	366,518	

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shalom Lichtman	Administrator	0	$ 50,726
Michael Elkes	Administrator	0	97,787
Sandra Cubas	Administrator	0	31,914
Joshua Baver	Administrator	0	23,801
Orlando Arjona	Asst. Admin	0	8,076
Tannis Tyler	Asst. Admin	0	46,171
Elizabeth Castaneda	Asst. Admin	0	18,575
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 277,050

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 1,123,279
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,123,279

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 301,081
CohnReznick LLP	Accounting	1,174
Plante & Moran, PLLC	Accounting	11,500
Richard Peelo & Associates, Inc	Accounting	2,800
Templin Healthcare Accounting Serv	Accounting	5,385
Personnel Planners	UC Consultant	1,776
Terrill Consulting Services, Inc.	Billing Consultant	40,276
See Attached Schedule 21A		316,308
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 680,300

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 209,098
Unemployment Compensation Insurance	71,134
FICA Taxes	746,606
Employee Health Insurance	461,429
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	23,382
Physical Exams	140
Pension Contributions	76,380
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,588,169

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	74,415
Health Care Worker Background Check	
(Indicate # of checks performed 208)	2,080
Patient Background Checks 469	4,691
Dues & Subscriptions	10,018
Licenses & Permits	325
The Joint Commission	8,500
Allocated from REX Therapeutics	23,952
Allocated from Management Co.	23,523
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 147,504

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,820
Allocated from Management Co.	1,056
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,876

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/19**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Ability Network Inc	Data Processing	3,482
Baver, Yocheved	Computer Services	10,800
Blymas Inc.	Tax Credit Consultant	19,253
Change Healthcare	Data Processing	641
E-Solutions	Data Processing	5,826
Experian Health Inc	Revenue Cycle Management	865
GCHMO, Inc.	Managed Care Contracting Services	36,150
HDSI	Data Processing	2,792
Healthcare Solutions Group	Benefits consultant	7,871
LTC Consulting Services	Medical Billing Consulting	1,902
Matrixcare	Data Processing	100,022
Paycor	Payroll Processing	50,538
Protek International Inc	Computer Services	2,521
Singer Networks, LLC	Data Processing	17,197
TaxSaver Plan	Benefits Administration	276
Resolute Healthcare Solutions	Healthcare Billing	23,321
Reality Based Group	Mystery Shopper	2,580
Dyatech, LLC	Benefits Consultant	1,075
Department of Labor	Labor Issue	980
First Midwest Bank	Field Audit	4,450
The Payton Company	Application Software	128
InPath Security, LLC	Data Processing	31,034
Medusind Solutions Inc.	Data Processing	5,266
SourceTECH	Data Processing	115
Miscellaneous	Miscellaneous	4,000
Accrual Reversals		(16,777)
Total		**316,308**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/19 Ending: 12/31/19

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **71,879** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **599,763**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.